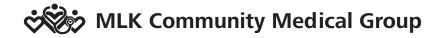


Patient Name:	
Date of Birth: _	

## **NEW PATIENT REGISTRATION FORM**

PATIENT INFORMATION					
Patient Name:					
Last		First		Middle	
Date of Birth:					
Marital Status: □ Married □ Sing		□ Widowed	·		
Race:					
Mailing Address:					
City:					
I'd like to receive appointment and					
Preferred Telephone # for Routine Com					
Secondary Phone:					
E-mail:					
Primary Care Provider:		-			
Employer:		Employer Phone	2:		
Work Address:		City:	Sta	ate:	Zip:
Address (Street or PO Box):					
Contact Name:				ent	
City:				ate:	Zip:
Home Phone: ()	Work Phone: (	)	Cell Phone	: ()	
PRIMARY RESPONSIBLE PARTY					
□ I am Responsible Party  □ Spouse 〔 	□ Parent □ Guardian	□ Other			
Name: Last		First		Middle	
Date of Birth:		Sex:			
Street Address:					
 City:				ate:	Zip:
Phone:					
Employer:					
Work Address:					
SECONDARY RESPONSIBLE PART	Υ				
Name:		□ Spouse □ Pai	rent □ Guardian	□ Other	
Employer:	·	Employer Phone	::		
Work Address:		City:	Sta	ate:	Zip:



Patient Name:	
Date of Birth: _	

## **NEW PATIENT REGISTRATION FORM**

## \*RACE AND ETHNICITY

Identify Race: We are required by Federal health care programs to request this information as a part of the demographic data they collect. Individuals are asked to indicate one or more races that apply from among the following or you may decline to specify.					
American Indian or Alaska Native Asian Black or African American	Native Hawaiian or Other Pacific Islander White				
Race Categories as defined by US Federal OMB:					
American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.				
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.				
Black or African American	A person having origins in any of the black racial groups of Africa.				
Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands				
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.				
Identify Ethnicity: We are required by Federal health care programs to request this information as a part of the demographic data they collect. Individuals are asked to designate their ethnicity from the following or you may decline to specify:					
Hispanic or Latino; or	Not Hispanic or Latino				
Hispanic or Latino defined	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin regardless of race				
Unknown Unknown/Not Reported					



Patient Name:
Date of Birth:
Date of Birth:
Date of Birth:
ler the subscriber indicated on my registration edical Group to provide healthcare services. erms of my medical and hospital subscriber o, if the above is not true, I agree to pay in full
Date:
rvice providers with a telephone number for uther King Community Medical Group or its ervice my account(s) (including contacting med the patient appointment and follow-up health atient appointments, and to collect any amounts ration Luther King Community Medical Group spective agents and contractors, including any contact med at the provided telephone number(s) contact may include using pre-recorded and ded) and/or the use of an automatic dialing ciated with my account number(s) and is not a posign this consent as a condition of receiving
ND ASSIGNMENT OF BENEFITS of, to pay directly to Martin Luther King King Community Medical Group. I am aware ent. I authorize refund of overpaid insurance s signature will also serve as an authorization

## NIEW DATIENT DECICEDATION FORM

Print Name of Guardian or Personal Representative (print)

NEW PATIENT REGISTRATION FORIVI			
INSURANCE INFORMATION			
Primary Insurance			
Company Name:			
Subscriber's Name:			
Relation to Patient:			
Subscriber's Address (if other than patient):			
Secondary Insurance			
Company Name:			
Subscriber's Name:			
Relation to Patient:			
Subscriber's Address (if other than patient):			
ELIGIBILITY GUARANTEE			
I hereby certify that I am eligible with the health insurance cor sheet. I also certify that I have chosen Martin Luther King Com I understand that if the above is not true or I am not eligible u agreement, I am liable for any and all charges for services reno for all services rendered within thirty days of receiving a bill.	nmunity Medical Group to provide healthcare services. nder the terms of my medical and hospital subscriber		
Signature:	Date:		
COMMUNICATION CONSENT By providing the Martin Luther King Community Medical Group a cellular or other wireless device and/or an e-mail, I agree that service providers may use the provided telephone number or eabout obtaining potential financial assistance for my account(scare reminders by text or e-mail, to send me information, to sell may owe to my healthcare provider(s). I understand and agree and its agents, representatives, or other service providers as we billing or account management companies and/or debt collect which could result in charges to me. I expressly consent that neartificial voice messages, text, email, (if an email address has be device, as applicable. This consent applies to all services and be condition of purchasing property, goods, or services. I am not healthcare services.	t Martin Luther King Community Medical Group or its e-mail to service my account(s) (including contacting me s)), to send the patient appointment and follow-up health chedule patient appointments, and to collect any amounts that Martin Luther King Community Medical Group ell their respective agents and contractors, including any cors may contact me at the provided telephone number(s) nethods of contact may include using pre-recorded and een provided) and/or the use of an automatic dialing illing associated with my account number(s) and is not a		
Initials / Approve Initials / Decli	ne		
<b>AUTHORIZATION FOR RELEASE OF MEDIAL INFORM</b> I hereby authorize and request the insurance company(s), or a Community Medical Group for services provided to me by Ma that I am financially responsible for charges not covered by thi benefits where my coverages are subject to coordination of be to release medical information necessary to satisfy payment.	gent thereof, to pay directly to Martin Luther King rtin Luther King Community Medical Group. I am aware s assignment. I authorize refund of overpaid insurance		
Signature of Patient (if minor, Signature of Responsible Party)			
Signature of Guardian or Personal Representative	Date		
•			

Relationship to Patient